ATTACHMENT 1

MISSOURI DEPARTMENT OF TRANSPORTATION AND MISSOURI STATE HIGHWAY PATROL

MEDICAL INSURANCE ENROLLMENT FORM

FOR RETIREMENT INFORMATION ONLY
Lump Sum Premium thru Cafeteria? ☐ Yes ☐ No
If yes, date deduction begins from retirement benefit ____

☐ NEW ENROLLMENT ☐ REFUSAL ☐ CHANGE ☐ CANCELLATION **EFFECTIVE DATE:** ____

REASON FOR CHANGE:

SUBSCRIBERS NAME (LAST, FIRST, MI)	SOCIAL SECURITY	DIV/DIST/TROOP	STATUS

SUBSCRIBERS ADDRESS		COUNTY	

☐ MALE ☐ FEMALE	BIRTH DATE	☐ SINGLE ☐ MARRIED	MARRIAGE DATE	MEDICARE ELIGIBLE ☐ YES ☐ NO ☐ PART A ☐ PART B	# OF MEDICARE PLANS ____ Attach copy of Medicare card

PPO PLAN CHOICES (Medicare Available)		**OPEN ACCESS III CHOICES** (No Medicare Available)		**Contribution**
☐ A (ONE-PERSON)	☐ B (SUB & SPOUSE)	☐ V (ONE-PERSON)	☐ W (SUB & SPOUSE)	paid by subscriber
☐ C (MULTI-PERSON)	☐ D (SUB & CHILD)	☐ X (MULTI-PERSON)	☐ Y (SUB & CHILD)	$
☐ F (SUB & 2 CHILDREN)		☐ Z (SUB & 2 CHILDREN)		

DEPENDENT NAMES (LAST, FIRST, MI)	BIRTH DATE	RELATIONSHIP	DISABLED*	MEDICARE ELIGIBLE YES	PART A	PART B
		**Spouse	☐	☐	☐	☐
		____	☐	☐	☐	☐
		____	☐	☐	☐	☐
		____	☐	☐	☐	☐
		____	☐	☐	☐	☐
		____	☐	☐	☐	☐

*Indicate disabled status if dependent has a mental and/or physical disability and is receiving 50% support from the subscriber.

Do you contribute 50% or more support to the dependents listed above?	☐ YES	☐ NO
Do the dependents listed above reside within your permanent residence?	☐ YES	☐ NO
Are all of the dependents listed above between the age of 19 and 23 full time students?	☐ YES	☐ NO
Will you or any of the above-listed dependents have any other health insurance in force?	☐ YES	☐ NO

☐ **S – My spouse is employed by MoDOT/MSHP, and I am included as a dependent on his/her medical insurance plan.
Spouse name & SS#: ____

☐ PPO ☐ Open Access ☐ Coventry ☐ Sub/Spouse ☐ Sub/Family

COMPLETE THIS PORTION FOR CANCELLATION OR REFUSAL

☐ C (Cancellation)	I have elected to cancel my Group Hospital Insurance. COBRA members, retirees, surviving spouses and vested members shall not be eligible to re-enroll.
☐ R (Refusal)	I hereby acknowledge I have been given an opportunity to participate in the MoDOT & MSHP Medical Plan. By refusing this plan at this time, I will be required to provide documentation of a qualifying event if I desire coverage in the future. I understand I have 60 days from my employment date to change my decision and participate in the plan.
☐ HMO	I have enrolled in an HMO.
☐ Refusal to Sign	I certify that the benefits of the plans, and the stipulation that enrollment in the future will be subject to a qualifying event if more than 60 days from employment date, were thoroughly explained to the subscriber and he/she has declined to participate and also refused to sign the above statement.

ENROLLMENT ACCEPTANCE

If my application for group insurance is accepted, I hereby authorize MoDOT or MSHP to deduct the amount required to pay premiums on such group insurance from my regular monthly earnings. This authorization shall remain in effect until such time as I notify MoDOT or MSHP to terminate such deductions or this policy is terminated. Misstatements made by a subscriber at the time of enrollment or by a participant at the time of incurred loss may be grounds for denying enrollment or payment of a claim. Please ensure that all dependents meet the dependency requirements of the Plan.

Subscriber's signature	**Date**
Insurance Representative's signature	**Date**

A-570 Rev 12-2003
Original – Employee Benefits
Copy – Payroll

Date Rec'd by Dist/Div/Troop

Date Rec'd by EB

ATTACHMENT 1

MISSOURI DEPARTMENT OF TRANSPORTATION AND MISSOURI STATE HIGHWAY PATROL
STATE PAID LIFE INSURANCE ENROLLMENT FORM

☐ NEW ENROLLMENT ☐ REFUSAL ☐ CHANGE ☐ CANCELLATION

Reason for Change: _____

EMPLOYMENT DATE:_____

SOCIAL SECURITY	SUBSCRIBERS NAME (Last, First, MI)	BIRTH DATE

BENEFICIARY DESIGNATION

I hereby designate the following as my beneficiaries under the group life insurance plan provided by the Missouri State Highway Commission, and reserve the right to change or revoke such designation at any time.

Primary Beneficiary	1	2	3
Relationship	1	2	3
Contingent Beneficiary	1	2	3
Relationship	1	2	3
Contingent Beneficiary	4	5	6
Relationship	4	5	6

ENROLLMENT ACCEPTANCE

Subscriber's signature	**Date**	
Insurance Representative's signature	**Date**	**Div/Dist/Troop**

REFUSAL or CANCELLATION

I acknowledge that if I refuse or cancel this life insurance plan, the State Contribution will still be added to the medical and life insurance funds and will not be applied to reduce my medical plan cost or paid to me directly.

Subscriber's signature	**Date**

(Complete when employee refuses to sign)

I certify that the benefits of the plan mentioned on this form were thoroughly explained to the employee and he/she has declined to participate and also refused to sign the above statement.

Insurance Representative's signature	**Date**

A-560 Rev. 04-2003
Original – Employee Benefits
Copy – Payroll (if payroll deduction is affected)

Date Rec'd by Dist/Div/Troop

Date Recd' by EB

ATTACHMENT 1

MISSOURI DEPARTMENT OF TRANSPORTATION AND MISSOURI STATE HIGHWAY PATROL

OPTIONAL GROUP LIFE INSURANCE ENROLLMENT FORM

☐ NEW ENROLLMENT ☐ REFUSAL ☐ CHANGE ☐ CANCELLATION **EFFECTIVE DATE:** _____

REASON FOR CHANGE OR CANCELLATION:

SOCIAL SECURITY	SUBSCRIBERS NAME (Last, First, MI)	BIRTH DATE

COVERAGE ELECTIONS

Maximum Insurance Available $_____ (up to 6 times annual salary, maximum of $800,000)

		Amount of Optional Life Insurance Elected	Rate/thousand for age bracket	Amount of deduction
Subscriber	Multiples of $1,000, not to exceed 6 times annual salary or $800,000	$	X =	**$ 0.00**
Spouse	Medical history required for over $10,000. Cannot exceed the greater of member's amount or $100,000.	$	X =	**$ 0.00**
Child(ren)	$10,000 coverage per child	N/A	N/A	**$**
			Total Premium	**$ 0.00**

SPOUSE AND CHILDREN INFORMATION

Social Security	Name	Relationship	Birth Date	Marriage Date

BENEFICIARY DESIGNATION

Primary Beneficiary	1	2	3
Relationship	1	2	3
Contingent Beneficiary	1	2	3
Relationship	1	2	3
Contingent Beneficiary	4	5	6
Relationship	4	5	6

ENROLLMENT ACCEPTANCE

I hereby authorize the selections made above and the deduction necessary to pay for the coverage elected and certify the above named are my spouse and dependent child(ren). I understand all elections will be effective in accordance with the terms of the group member policy and amendments hereto. I understand by refusing this plan, I will be required to provide evidence of insurability acceptable to the insurance carrier in the future. I understand I have 31 days from my employment date to change my decision and participate in the Plan without evidence of insurability.

Subscriber's signature	**Date**	
Insurance Representative's signature	**Date**	**Div/Dist/Troop**

REFUSAL (complete when employee refuses to sign)

I certify that the benefits of the plan mentioned on this form were thoroughly explained to the employee and he/she has declined to participate and also refused to sign the above statement.

Insurance Representative's signature	Date

A-560E Rev. 04-2003
Original – Employee Benefits
Copy – Payroll (if payroll deduction is affected)

_____ Date Rec'd by Dist/Div/Troop

_____ Date Recd' by EB

ATTACHMENT 1

MISSOURI DEPARTMENT OF TRANSPORTATION
AND MISSOURI STATE HIGHWAY PATROL

OPTIONAL GROUP LIFE INSURANCE – RETIREES

Social Security Number	Name (Last, First, Middle Initial)	Bus Code (MM/YYYY) Dist/Div/Troop

☐ New Enrollment ☐ Change Reason for Change
☐ Refusal ☐ Cancellation

Birthdate (MM/DD/YYYY)	Age	Retirement Plan	Effective Date
		☐ **Closed Plan** ☐ **Y2000 Plan**	

1. **MAXIMUM INSURANCE ELIGIBLE** (Retiree must have been covered by the State Furnished Insurance.) See bottom of form for maximum insurance eligible.	$
2. **AMOUNT OF OPTIONAL STATE SPONSORED LIFE INSURANCE DESIRED** (Amount, in $500 multiples, up to the maximum insurance eligible)	$
3. **Rate per $500**	$
4. **MONTHLY PREMIUM**	$ 0.00

Primary Beneficiary	1	2	3
Relationship	1	2	3
Contingent Beneficiary	1	2	3
Relationship	1	2	3

If more than one primary or contingent beneficiary is named, the death benefits, unless otherwise provided herein, will be paid in equal shares to the designated beneficiaries who survive the Retiree. If no beneficiary survives, the payment will be made to the insured's estate.

I hereby accept the Optional Group Life Insurance in the amount indicated above and authorize, until revoked by me in writing, deduction from my regular monthly retired pay an amount sufficient to cover the premium under said Optional Life Insurance Contract.

SIGNATURE OF RETIREE	**DATE SIGNED**
SIGNATURE OF INSURANCE REPRESENTATIVE	**DATE RECEIVED**

REFUSAL

I hereby acknowledge that I have been given an opportunity to participate in the Optional Group Life Insurance Plan. I understand that if I decline participation at this time, I cannot enroll after retirement.

SIGNATURE OF RETIREE REFUSING INSURANCE PRIOR TO RETIREMENT	**DATE SIGNED**

TO BE COMPLETED WHEN RETIREE REFUSES TO SIGN

I certify that the benefits of the plan mentioned on this form were thoroughly explained to the retiree and he or she has declined to participate and also refused to sign the above statement.

SIGNATURE OF SUPERVISOR OR INSURANCE REPRESENTATIVE	**DATE SIGNED**

Closed Plan – Employees retiring under the Closed Plan may not retain more than $60,000. If the state paid coverage and optional life coverage amounts carried as an active employee do not equal $60,000, and the retiree wishes to carry $60,000, evidence of insurability must be provided and approved prior to retirement. The retiree may elect optional life coverage in the amount of state paid coverage, if only enrolled in state paid coverage as an active employee.

Year 2000 Plan – Employees retiring under the "Rule of 80" (at least age 50 with age + service years equaling 80) in the Year 2000 Plan may retain the same amount of optional life insurance coverage that was in effect during the month prior to leaving state employment. When retirees reach age 62, they can retain insurance in an amount no greater than the amount in effect during the month prior to attaining age 62 not to exceed $60,000.

A560R Rev. 04-2004

ATTACHMENT 1

MISSOURI DEPARTMENT OF TRANSPORTATION
ASSOCIATION GROUP LIFE INSURANCE ENROLLMENT FORM

☐ NEW ENROLLMENT ☐ REFUSAL ☐ CHANGE ☐ CANCELLATION **EFFECTIVE DATE:** _____

REASON FOR CHANGE OR CANCELLATION:

SUBSCRIBERS NAME (LAST, FIRST, MI)	SOCIAL SECURITY	BIRTH DATE	STATUS

COVERAGE ELECTIONS

		Amount of Association Life Insurance	Rate/thousand for age bracket	Amount of deduction
Member	Based on annual salary and Class Class _____	$	X =	$ 0.00
Dependent	Include spouse and/or child(ren)? Yes☐ No☐	N/A	N/A	$
			Total Premium	$ 0.00

BENEFICIARY DESIGNATION

If more than one beneficiary is named, the death benefits, unless otherwise provided herein, will be paid to the designated beneficiary, if living at the death of the insured, if not then living to the Contingent Beneficiary or Beneficiaries, if so designated. If no beneficiary survives, the payment will be made in accordance with the terms of the policy.

Primary Beneficiary	1	2	3
Relationship	1	2	3
Contingent Beneficiary	1	2	3
Relationship	1	2	3
Contingent Beneficiary	4	5	6
Relationship	4	5	6

ENROLLMENT ACCEPTANCE

I hereby authorize the selections made above and the deduction necessary to pay for the coverage elected and certify the above named are my spouse and dependent child(ren). I understand all elections will be effective in accordance with the terms of the group member policy and amendments hereto. I understand by refusing this plan, I will be required to provide evidence of insurability acceptable to the insurance carrier in the future. I understand I have 31 days from my employment date to change my decision and participate in the Plan without evidence of insurability.

Subscriber's signature	**Date**	
Insurance Representative's signature	**Date**	**Div/Dist/Troop**

Refusal of Participation (complete when employee refuses to sign)

I certify that the benefits of the plan mentioned on this form were thoroughly explained to the individual and he/she has declined to participate and also refused to sign the above statement.

Supervisor's or Insurance Representative's signature	Date

A-435 Rev.04-2003
Original – Employee Benefits
Copy – Payroll (if payroll deduction is affected)

Date Rec'd by Dist/Div/Troop

Date Recd' by EB